DOCUMENT RESUME

ED 082 898 RC 007 359

TITLE	Handbook for Public Health Nurses Working with Spanish-Americans.
INSTITUTION	Community Health Service (DHEW/PHS), Bethesda, Md.
PUB DATE	Jan 71
NOTE	52p.; Reprinted January 1971, first printed June 1964
EDRS PRICE	MF-$0.65 HC-$3.29
DESCRIPTORS	Attitudes; Beliefs; *Communication (Thought Transfer); Diseases; Interpreters; *Nurses; Patients (Persons); *Public Health; *Rural Population; *Spanish Americans
IDENTIFIERS	*Northern New Mexico

ABSTRACT

Prepared for the use of public health nurses working with rural Spanish Americans in northern New Mexico, this handbook presents information and suggestions, in outline form, to aid these nurses in communicating with their patients with better understanding and cooperation. The handbook is based on the findings of a study conducted between September 1958 and July 1963 in Health District #1 of northern New Mexico. The study's purpose was to observe whether the quality of communication between nurse and patient and the degree of cooperation obtained from patients varied with the following 4 factors: (1) the setting in which the contact took place; (2) attributes of patients such as age, sex, language facility, and education; (3) nurse performance variables such as language used, length of the interview, and use of visual aids or written materials; and (4) discourse variables such as use of complete, appropriate arguments and "adequate" explanations. Topics discussed in the handbook include: the patients; health beliefs and linkage; sickness; respiratory, children, and traditional diseases; treatment; traditional practitioners and their areas of competence and interests; first visit; use of an interpreter; arguments; explanations; folk attitudes relevant to public health; and general rules. (NQ)

ED 082898

HANDBOOK FOR PUBLIC HEALTH NURSES

Working with SPANISH-AMERICANS

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

Prepared by the Bureau of Sociological Research, Institute of Behavioral Science, University of Colorado, and the New Mexico State Department of Public Health under a grant from the Public Health Service. Grant No. CH-0009-05 (RG-5615).

RC007359

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Health Services and Mental Health Administration
Community Health Service
Reprinted January, 1970

FILMED FROM BEST AVAILABLE COPY

CONTENTS

	Page
The Patients	1
Health Beliefs and Linkage	5
Sickness	9
Respiratory Diseases	14
Children's Diseases	18
Traditional Diseases	21
Treatment	25
Practitioners	27
First Visit	29
Interpreter	33
Arguments	37
Explanations	41
Attitudes	47
General Rules	49

INTRODUCTION

This handbook has been prepared for the use of public health nurses working with rural Spanish-Americans in northern New Mexico. It presents, in convenient outline form, information and suggestions that should be useful to nurses in their efforts to communicate with patients in ways that will enhance understanding and cooperation. It is intended for use with the more detailed **Nurse-Patient-Communication: A Manual for Public Health Nurses in Northern New Mexico** and with **An English-Spanish Glossary of Basic Medical Terminology in the Dialect of Northern New Mexico.**

The recommendations and suggestions made here are not designed as rigid rules that must be followed if communication is to be successful. They are, rather, intended as aids to communication which, if followed to the point of becoming habitual, may increase the probability of understanding and cooperation in a given instance of contact with a patient and should increase the amount of understanding and cooperation among a total case load over a period of time.

The materials of this handbook, like those of the **Manual** and **Glossary**, are based on the findings of a research undertaking (supported by a grant–RG5615 and CH00009-05 from the National Institutes of Health) that was carried on in Health District #1 between September 1958 and July 1963. One interest of that research was to learn something about how patients' understanding of what nurses said and their cooperation in what nurses asked them to do varied with four factors in communication situations. These were: (1) the setting in which the contact took place (for example, in the home of the patient or in the clinic), (2) attributes of patients (for example, their age, sex, language facility, amount of education), (3) nurse performance variables (for example, language used, length

of the interview, use of visual aids or written materials, and (4) discourse variables (for example, use of complete, appropriate arguments and "adequate" explanations). The "rules" presented here have been derived from what was learned in this part of the research. Thus they are based on a statistical assessment of what actually was observed to happen in real nurse-patient contacts in the area in which presumably nurses who use this handbook will be working.

Many of the factors that influence quality of communication between nurse and patient and the degree of cooperation obtained from patients are, of course, not subject to control by the nurse. But she can to some extent control her own performance and discourse in the contact situation and, by so doing, hopefully alter the balance of factors that affect the outcome of communicative efforts. It is to provide help in the attainment of some aspects of that control that this handbook aspires.

RURAL HEALTH SURVEY

Lyle Saunders
Robert Hanson
Marion Hotopp
Mary Marquez
Connie Pacheco

SANTA FE, NEW MEXICO
JUNE, 1964

THE PATIENTS

People of the County

The people who live in Health District #1, like those anywhere, have characteristics that affect their relationships with nurses. Among the more important group characteristics that the nurse should have in mind and take account of when dealing with patients are the following:

1. These are **rural** people. Being rural implies more than just a classification of a place of residence. It implies also a way of thinking, a way of relating to people and events, a way of orienting to one's social and physical surroundings. Rural people usually have to depend on themselves and on their families and friends for a wider range of goods and services than do city people. Their resources for meeting problems, including problems of health, are likely to be somewhat more limited than those of city people. The hospital, the clinic, the laboratory, the x-ray machine, the professional practitioner are urban. Rural people learn about them and use them when their problems indicate such use and when their resources permit. But the opportunity to learn must occur before the learning; and use is likely to be somewhat more difficult, both physically (because of distance) and psychologically (because of relative unfamiliarity), than it is for most urban people.

2. Patients encountered in this District are **Spanish-American**. Eight out of ten of the people of Rio Arriba and Taos Counties are. This does not mean they are foreigners. On the contrary, these patients are descendants of some of the earliest Europeans to settle in **North America**. They are **not** Mexicans, although they may occasionally refer to themselves as **mejicanos**.

3. As descendants of the Conquistadores and their followers, they are **Spanish-speaking**. Most Spanish-Americans are bi-lingual,

speaking Spanish and English equally well. A few, generally older people, may not know much or any English. Others, for some kinds of communication, may feel more comfortable in Spanish than in English. Many modern health concepts are probably better expressed in English than in Spanish because the local language has not developed terms for them. Older, more familiar health concepts may be at times more readily understood in Spanish. Choice of language is a continuing problem for English-speaking people working in the area. One of the best bits of advice that can be given to such persons is: learn Spanish.

4. These are residentially **stable** people. Nearly everyone encountered as a patient will have been born in New Mexico. Most will be from communities where they and their families have lived for many generations. There is a slow drift of people out to other areas—mainly young people who go out to seek work and other opportunities—but not much moving around in the area. People are likely to know a good deal about other people in their community and neighboring communities.

5. Patients, as a group, are likely to be quite **religious.** For some, commitment to religion may be more a matter of inward conviction and faith than of outward behavior and thus not particularly obvious. Membership in the Catholic faith provides a strong force toward mutual identification and unity among the population. Religious considerations permeate health beliefs and health actions. Traditional treatments may have a religious component, such as the sign of the cross or the names of the Holy Trinity. Many persons believe that disease occurs only because God wants it to or permits it to. Environmental influences tend to be viewed as **agents** of disease (as one lady said, "they do the work"), but God is seen as the ultimate cause of disease. The idea of God as the ultimate cause of disease and of sickness as an expression of His will may not be frequently expressed to a nurse, but it will be frequently present as a pervasive influence affecting health understanding and action.

6. As a group, and judged by present day standards, the patient group is **not well educated.** This does not mean that they are not intelligent. Intelligence is a matter of genetic endowment;

education is ordinarily a matter of school attendance. The two should not be confused. Lack of education does, however, mean the possibility of relative unfamiliarity with many concepts and a relatively meager vocabulary. A vocabulary test given as part of the research showed less than half the respondents understanding such common public health terms as primary, sputum test, respiratory, isolate, symptoms, exposed, relapse. An implication is that one needs to be especially careful of the language and concepts used when giving instructions or information to people of relatively little formal education. Lack of education also means lack of knowledge about many aspects of modern hygiene and the principles of health protection and maintenance. Helping to supply such knowledge is one task of nurses. Those who have worked at this task know that a single 'telling' is rarely enough; skill and patience and time are required.

7. It is fair to say that the patients, as a group, are **poor**, although it must be remembered that poverty is a relative matter. Per capita income in Rio Arriba County is about half that of New Mexico and about a third of the average for the United States. Few families are likely to have adequate health insurance; relatively few families are able to spend much for health maintenance or recovery. Even costs of travel to a clinic or the loss of income incurred when a breadwinner has to seek preventive or treatment services may produce serious financial problems for a family.

8. Patients are generally **members of families**. Most, if we may judge by the patients seen by nurses during the research period, live in the familiar husband-wife-children family pattern. About one in four lives in a complex family that includes, in addition to husband, wife, and children, parents or siblings of the adults. Almost no one lives alone. Comparisons are not very meaningful, but it may be fair to say that Spanish-American family ties are often stronger and more widely extended than those typical of Anglo-American families. The family is of concern to a nurse because it is in the family usually that the first diagnosis of sickness is made and the first treatment decisions taken. Families are a source of information and of help when a member is sick. Other members may exercise a strong influence over the course of events when a member is ill. That

influence may be a source of help or hindrance to the efforts of the nurse. Families in this area are traditionally patriarchal, but there seems to be no clear cut division of labor with respect to health decisions. Either husband or wife of the family group may make them. It is important to try to learn, for any given family, which does.

9. The patient group comes from a **distinctive culture** that is very much like and a little different from the Anglo-American culture. The Spanish-American way of life was developed long before Anglo-Americans came to New Mexico. Both groups have been changing in their century and a half of contact, but there still remains a recognizable core of Spanish-American culture. Individuals may range from those who think and believe and behave exactly like their Anglo-American counterparts to those—mainly a few older people—who still retain a fair amount of the traditional culture. The fact of some cultural difference should not be viewed as an overwhelming problem; neither should it be entirely ignored. It exists; it influences some aspects of nurse-patient relationships, including communication; it should be recognized and, where it is helpful to do so, taken into account in nurse-patient interaction.

10. Finally, patients are **laymen.** They are not professionally involved in health. Health for them is likely to be of somewhat less central importance than for nurses. They have not had training in health matters; they do not speak the technical language of the health professions; they are likely to care less about community health than about that of themselves and their families. For them, health and illness are likely to be matters of feeling well or not well, of having or not having such symptoms as pain, nausea, fever, bleeding, dizziness, weakness. For them, illnesses tend to be conceptualized in terms of fairly clear cut recognizable disease states such as colds, influenza, pneumonia, or in more or less vaguely localized "troubles" such as heart trouble, kidney trouble, stomach trouble. The nurse knows a great deal about the sub-cultures of medicine and public health, an important part of her work is to translate this knowledge into explanations and suggestions that somehow fit in with the knowledge and conceptions patients have. It is most essential that she know something about how this group of laymen views health and illness.

HEALTH BELIEFS AND LINKAGE

How anyone behaves with respect to sickness is, in part, a reflection of a set of values and beliefs that he holds. Nurses want to immunize children against diphtheria because they accept the value premise that health is better than sickness and because they believe that immunization will keep children from having diphtheria. Mothers cooperate in having their children immunized because they share the same value and the same belief.

A few health beliefs may be private in the sense of being held only by an individual or a family; the great majority of them are shared with many other people. Many are so common that they can be said to apply to an entire population, even though everyone may not perceive them or accept them in exactly the same way. Where beliefs and values are shared, people understand each other better and cooperate more easily than where different sets of values and beliefs are held. For example, some patients in the District think that **osha** is a good remedy for some types of stomach disorder. Nurses generally do not share this belief. If a patient and nurse were to talk in this area agreement would be difficult unless one were able to convince the other that his belief was wrong. This would not be easy because each would be supported by the knowledge that other people share his belief. How can the belief be wrong when "everybody knows" that it is right?

To greatly oversimplify the matter, there are at least two sets or systems of shared health beliefs influencing what people do about health in the District. One is that of public health; one is that of the patients. There are many beliefs (and supporting values) that are common to both sets; there are some that are only in one set or the other. Both sets, for example, include the general belief that eating the right kinds of food will contribute to healthy growth; the idea that a particular kind of food (say, candy) is among the "right"

kinds is probably more acceptable to patients than it is to the public health group.

Beliefs common to both sets may be viewed as **linkage points**. Linkages, when explicitly brought to attention, constitute important points of established agreement from which to begin the persuading or teaching about matters on which there is not such agreement.

It is suggested that whenever possible, nurses should use a linkage concept or idea as the basis for common understanding when trying to communicate a new idea to a patient.

It is not possible to list all the linkages between the public health and patient belief systems. The following can serve to illustrate linkage. Each nurse will be able to think of and use many more.

1. An important linkage value is the conviction that it is better to be healthy than sick.

2. Another is a **basic premise** that seems to underlie the rationale for all health actions in both sets of beliefs: one should do whatever is necessary to maintain or regain health.

3. People have resistance to disease. A person whose resistance is strong may not get sick in circumstances where a person whose resistance is weak will get sick.

4. It is possible for a person to preserve or improve his own health by actions he takes.

5. Sickness can spread from one person to another.

6. Some people know more about how to diagnose and treat sickness than others. Specifically, doctors and nurses know a great deal about sickness and health.

7. The x-ray is a useful procedure for diagnosing illness.

8. Immunications will help keep people from having certain diseases.

9. A person who is weak or tired or thin may be more susceptible to illness than one who is strong, active, and robust.

10. Natural phenomena (e.g., cold, wind, wetness, heat) can contribute to sickness.

In using linkage it is the **idea**, not the specific wording, that matters. The first two illustrations listed above are appropriate for any kind of health discussion and should be explicitly stated, in some form with which the individual nurse is comfortable, in all health discussions with patients. It is to be expected that at first nurses may feel a little awkward in stating such obvious viewpoints. But it is precisely because they are obvious (well known and generally accepted) that it can be certain that they will constitute a point of agreement which further discussion can hopefully expand. These are viewpoints that patients already understand and accept. By bringing them to explicit attention, the nurse will make both herself and the patient aware that there is a basis of prior agreement on which further discussion can build. The principle is that of starting with what the patient and nurse both understand. then requests and explanations made by the nurse later in the conversation can be consistent with the common foundation of understanding developed at the beginning.

Other linkages should be used whenever they seem appropriate in terms of the specific subject matter being discussed. They do contribute toward increasing the probability of understanding and cooperation.

SICKNESS

Conceptions of health: Health is perceived in the patient group as a day-to-day matter, always important, but usually appraised in terms of the present. There is little attention given to how it came to be or how it might develop, positively or negatively, in the future. Health is normal; normal people are healthy. With regard to health there is little or no conception of perfection or (while healthy) of improvement. There is an idea of adequacy. So long as an individual can fulfill his normal roles—can do what is expected of his age, sex, position—he can be considered healthy. The most common criteria of health are the ability to maintain a high level of normal physical activity, a sturdy body, and an absence of continuing pain or discomfort. Anyone who has these will be difficult to persuade that he is sick.

Symptom recognition: The patient group, like all other people, recognize and define illness on the basis of combinations of objective and subjective symptoms. The following are some of the symptoms that are likely to have meaning to them. Please note that these are not exclusive to this group, nor is the listing exhaustive:

1. General changes that raise questions about health:

   A. Radical changes in **appearance**, such as loss of weight, increased pallor, dulling eyes, deteriorating posture.

   B. Radical changes in **activity** levels or routines, such as loss of appetite, inability to sleep, impaired ability to work or play.

   C. Radical changes in **mood**, such as increased sadness, depression, nervousness.

D. Persistence or aggravation of minor symptoms, such as those listed under 3. below.

Note that the illustrations given here are those associated with the likelihood of definitions of illness. The converse of these symptoms—e.g., weight increase, brightening eyes, return of appetite, improved ability to work—leads to definition of returning or regained health.

2. Symptoms regarded as serious when persistent or severe and that may lead to seeking some kind of relief or help: pain, bleeding, vomiting, convulsions, chills, fever, dizziness, excessive perspiration, deep productive cough, lumps under the skin, spitting blood.

3. Minor symptoms, not considered urgent or serious unless they persist or become severe: slight cough, running nose, headache, constipation, mild diarrhea, muscle soreness or cramp, indigestion, minor lacerations.

Health maintenance: For most people in the patient group, as for most laymen generally, health maintenance is more a matter of routines and habits than of conscious concern. Good health is maintained by good habits, that is by following a traditionally familiar set of actions assumed to promote continued normal health. Among the avenues to continued health are the maintenance of an adequate level of physical activity, the ingestion of proper foods and fluids in moderate amounts; good habits of evacuation, a balance between activity and rest, early sleeping and early rising, and the practice of moderation in all things. (It should be noted that there are many opportunities for linkage here.)

Disease prevention: Beliefs and values about specific prevention are difficult to summarize. Immunizations and vaccinations are accepted when offered; many in the patient group would probably actively seek them if they were not readily available. More general kinds of behavior that might be related to prevention of air-borne, water-borne, or other communicable diseases seem to be not so widely understood or practiced. It is doubtful if the notion of

specific prevention, in the definite sense in which it is accepted in public health, is held by a substantial majority of the patient group. A more likely point of view is one that might go something like this: since a person doesn't know what sickness he might get, since there is no certainty that any action will lead to or prevent an illness (e.g., people who drink out of ditches are not all sick; people who share the cup of a tuberculosis patient don't always get sick; babies stay healthy even though a dog takes a lick at their bottle as it rolls on the floor), and since it is God who ultimately decides whether or not a particular person is going to get a particular disease, there is no need to go to much trouble about prevention.

Causes of illness: Members of the patient group know many things that cause illness. Some are similar to those recognized by public belief system. Causative factors can work alone or in combination. There is no single theory of disease causation that explains all illness conditions; rather there are many explanations. From the Hispanic past there are unclear lingering notions of imbalance in the hot and cold elements in the body and in the body's humors; from Anglo-American culture have come often poorly understood ideas about the role of micro-organisms as causative agents in disease; from remote times there comes the now faintly held idea of object intrusion and the also rare idea of witches as causes; from village tradition there are beliefs about the illness-producing power of cold air, cold water, sudden temperature change, exposure. A first cause, however, in all illness, as in all human affairs, is God's will, operating sometimes through conceptions of destiny or fate.

A six-fold classification of causes was made in an early phase of the research. The categories developed there were:

1. Direct punitive action of God—**castigos** or punishments that God for His reasons inflicts on an individual or family.

2. Exposure to the forces of nature—heat, cold, winds, storm, sun, water, moonlight, eclipses may cause sickness or defect if a person is subjected to them at critical times.

3. Natural adversities—the illnesses associated with age and sex, with the ordinary experiences of life.

4. Person caused illnesses—conditions resulting from physical violence, from the actions of witches, from being frightened or shocked by the persons or action of other people, from the ill-defined processes by which some people are thought to give others such traditional ailments as, for example, **encono**.

5. A disturbance or imbalance of the body or the environment or of behavior—from excessive work or worry, over or under eating or drinking.

6. Other causes, such as the development of one illness from another, as when a cold progresses into pneumonia; failure to take proper care of one's self; encounter with diseases that are "going around."

There are obviously many linkage points between what parents believe and what public health accepts as causes of sickness.

Diagnosis. In the public health belief system, only a physician is believed competent to say what a sick person is suffering from, and he can do it only by taking a history, making an examination, and supplementing these with laboratory tests. Among the patients, as among other groups of laymen, diagnosis is viewed as less difficult, and lay practitioners as well as just laymen are thought capable under some circumstances of making a diagnosis.

The diagnostic procedures used in the group take account of physical signs and symptoms, may involve a test of some kind, and will often include some assessment of what are believed to be relevant environmental circumstances—such as a recent fright, a gift of food, a change of mood or activity. Some patients do not see anything incongruous in the idea that one person can, simply by looking at another, tell what illness he has.

Disease recognition. Like other people, patients have ideas about when children are sick or well, the names and natures of the sicknesses that afflict them, and about causes, preventive measures, and treatment. These ideas by now are a mixture of old traditional beliefs, modified by time, with those that have come from numerous modern sources of health information. Some of the notions are quite sound in terms of modern medical knowledge; others are much less so. A selection of their ideas, relating to a few of the more common diseases, are summarized on the following pages.

RESPIRATORY DISEASES

Colds - (Resfrios)

Etiology:

Getting chilled and exposure to drafts which produce an imbalance in body heat. Some villagers believe colds to be communicable, but probably most do not.

Symptoms:

Running nose, stuffiness in head, nasal and chest congestion and possibly slight cough and expectoration.

Diagnosis:

In children by mother and self-diagnosis by adults.

Treatment:

Palliative, including home remedies. If symptoms become aggravated, the services of a folk practitioner may be sought. Hot and sweet herbal teas including anise and juniper are often taken; penetrating mixtures such as lard and turpentine or a menthol preparation may be used in massage to relieve congestion.

Precautions:

Specifically, none. However, protective measures such as avoidance of undue exposure and proper diet are encouraged.

Remarks:

Untreated or aggravated colds are believed to lead to more serious upper respiratory infections, including pneumonia and tuberculosis.

Influenza

Etiology:

Aggravated or untreated cold.

Symptoms:

Same as for a cold, except more severe and of longer duration.

Diagnosis:

Self-diagnosis or self-evident if there is an influenza epidemic in community.

Treatment:

Menthol preparations or a suitable substitute which is penetrating and produces sweating.

Precautions:

Same as for a cold.

Pneumonia - (Pulmonia)

Etiology:

Precipitated by an untreated cold, exposure to cold and/or dampness.

Symptoms:

Chest and head congestion, moderately severe pain in the chest, fever, weakness, productive cough, shortness of breath.

Treatment:

Home remedies at outset and later those of medica. For example, a toasted onion poultice may be placed on the chest to act as an irritant. Bedrest. Attempts to "break" the fever are made by adding bed covers. Herbal teas.

Precautions:

Same as for a cold; no isolation procedures since it is usually thought not to be contagious.

Remarks:

Considered a serious illness.

Tuberculosis - (Tis)

Etiology:

1. Heredity
2. Punishment by God for past sins.
3. Evil intent of witches.
4. Over-work or emotional strain.
5. Excessive worry or emotional strain.
6. Untreated cold or chest ailment–in this sense, seen as a complication.
7. Physical contact or proximity to sick person–**tis prendido.**

Symptoms:

Loss of weight, sallow complexion, "yellowish" eyes, fatigue and general prolonged run-down condition. Cough may or may not be present.

Diagnosis:

Not made by family although it might be suspected.

Transmission:

The notion of communicability is not generally understood. However, **tis prendido**, one type of tuberculosis, connotes the idea of physical proximity in the transmission of the disease.

Treatment:

A wide variety of **remedios** and herbs are used to treat the symptoms of tuberculosis. Some of these are **yerba del apache, inmortal,** and **basil, anise** and **copalquin,** and **osha.** Services of a folk practitioner might be sought in the early stages of tuberculosis when it is recognized as another entity. Isolation procedures are not utilized in the home setting.

Precautions:

Same as for colds plus the **remedios** mentioned above. In addition, chili, goat's milk, onions and lemons are used more

or less frequently to maintain the body's strength as they are considered nutritious, just as "vitamins" and other "health foods" are taken by more acculturated persons.

Remarks:

A combination of fear, reluctance, and shame prevail in the household when it is known that a family member has tuberculosis. This is particularly true when the patient is an adult. Some villagers believe that tuberculosis cannot be cured. Others may have the idea that the X-ray is a therapeutic device.

CHILDREN'S DISEASES

Chicken-pox - small pox (Viruela)

Etiology:

Chicken-pox is viewed as a common childhood disease, not clearly differentiated from smallpox. May be recognized as "catching" with no clear understanding or transmission process.

Symptoms:

Pox following initial symptoms of respiratory illness.

Treatment:

Remedios to cut fever and discomfort, unless complications occur. For example, a paste of **contra yerba** (caltrop) may be used to reduce discomfort.

Prevention:

Immunization for smallpox. No special isolation procedures if the disease is contracted.

Diarrhea - (Diarrea)

Etiology:

Common childhood disease, not ordinarily considered to be serious. Not communicable. Often attributed to teething or to ingestion of unfamiliar or irritating food, or to the use of unboiled water with babies less than 6 months old.

Symptoms:

Loose bowels.

Treatment:

Remedios and patent medicines.

Prevention:

No special precautions, except that boiled water may be given to infants by some.

Diphtheria - (Difteria)

Etiology:

Serious childhood disease; may be recognized as catching with no clear understanding of transmission process.

Symptoms:

Severe throat pain and inflammation.

Treatment:

Remedios and patent medicines.

Prevention:

Immunization, priestly blessings; no special isolation precautions.

Measles - (Sarampion)

Etiology:

A common childhood disease; may be recognized as "catching" with no clear understanding of transmission process.

Symptoms:

Measles rash.

Treatment:

No special restrictions or treatment unless fever is high. Then the child may be kept in bed in a darkened room and given tea or **asafran** (sassafrass) to help the rash come out.

Prevention:

No special precaution; may invite onset by letting well children play with the sick child.

Mumps - (Mompes)

Etiology:

A common childhood disease; may be recognized as "catching" with no clear understanding of the transmission process. Can only be gotten once.

Symptoms:

Swollen neck and face.

Treatment:

Remedios to ease pain, such as a paste made of vinegar and baking powder. Beans should not be eaten.

Prevention:

No special precautions.

Whooping Cough - (Tos ferina)

Etiology:

A common childhood disease; may be recognized as "catching" with no clear understanding of transmission process.

Symptoms:

Bad cough.

Treatment:

Remedios with no special restrictions on the child unless coughing is severe. Children with harsh coughs may be taken out-of-doors to facilitate breathing and prevent smothering. Modern medical attention will likely be sought for a seriously ill child.

Prevention:

Immunization.

TRADITIONAL DISEASES

Some diseases still occasionally recognized in the patient group derive from the Spanish cultural tradition and have no counterparts in the public health belief system where the presenting symptoms are usually diagnosed as something else. Among these are:

Aigre - (Bad Air)

Etiology:
Undue exposure to drafts.

Symptoms:
Nausea, vomiting, headache, dizziness, swelling of affected area.

Treatment:
Remedios.

Prevention:
Avoidance of drafts and night air.

Empacho - (Intestinal Obstruction)

Etiology:
Adherence of food to intestinal wall of child.

Symptoms:
Bloating, loss of appetite, abdominal pain.

Treatment:
Massage of abdomen with raw egg; massage of back; laxative given following massage.

Prevention:

Dietary precautions (e.g., not eating too much freshly baked bread).

Encono - (Festering of Wounds)

Etiology:

Caused unintentionally by the presence of specific individuals called **enconadores** (infectors).

Symptom:

Festering of wounds.

Treatment:

Remedios.

Prevention:

Avoidance of **enconadores**, if known.

Mal Ojo - (Evil Eye)

Etiology:

Inflicted unintentionally on a child by an adult through great admiration expressed or unexpressed.

Symptoms:

Sudden radical change in physical well-being and/or temperament.

Treatment:

Transfer of water from mouth of suspected adult to mouth of child, or spit-spraying child.

Prevention:

Wearing of coral or obsidian.

Maleficio - (Witchcraft)

Etiology:
Malevolent magic.

Symptoms:
Highly variable; inexplicable physical or mental abnormality.

Treatment:
Consultation of an **albolario.**

Prevention:
Minimized or avoided by religious practice or the use of protective amulets.

Melarchico - (Melancholy)

Etiology:
Change in immediate environment, such as separation from a loved one; usually occurs in children.

Symptoms:
Depression, loss of appetite.

Treatment:
Increased T.L.C.

Prevention:
None.

Mollera Caida - (Fallen Fontanelle)

Etiology:
Soft palate of infant falls, causing anterior fontanelle to sink.

Symptoms:
Inability to suck.

Treatment:

Pressure applied to roof of mouth with thumb; sugar and water then placed upon fontanelle.

Prevention:

Gentle removal of bottle from baby's mouth.

Susto - (Fright, Shock)

Etiology:

Fright, emotional shock.

Symptoms:

General malaise, insommnia, nightmares, depression.

Treatment:

Remedios and/or massage.

Prevention:

Avoidance of potentially disturbing situations by frail individuals; often unforseen and therefore unavoidable.

TREATMENT

When faced with a need for relief or cure of illness, members of the patient group can choose from two broad and overlapping treatment traditions–"folk" medicine and "scientific" medicine. Which is chosen in a particular instance (and it may well be aspects of both) depends on a great variety of factors, among which are the nature and severity of the illness, experience with this and other illnesses, experience with both medical traditions, estimates of the financial and psychological costs of one or the other, availability of practitioners or treatment materials, degree of faith in one type of treatment or another.

Regardless of which treatment alternatives are chosen, patients are likely to expect that their symptoms will be promptly relieved and that recovery will be rapid and complete. Tentative diagnosis, delays in diagnosis, the probability of prolonged treatment may lead to "trying something else".

Traditional medicine includes a wide range of practitioners, procedures, and therapeutic materials about which knowledge is widely diffused among the group. For a given set of symptoms (and treatment is often directed at symptoms) there are likely to be a number of remedial choices–one source lists 46 remedies for rheumatism! If one is uncertain about how to treat an illness, there are always relatives and friends to offer advice and help.

Traditional remedies–locally called **remedios mejicanos** or, more simply, **remedios**–include herbs grown especially in one's garden, plants gathered from wild growths in the fields, and a variety of household and patent medicines that can readily be bought at drug and grocery stores or mail order houses. They have the advantages of being familiar, available, relatively inexpensive, and supported by group lore and group consensus. For most illnesses,

treatments are likely to begin with **remedios**; for many, treatments also end with them.

Scientific medicine is not likely to be perfectly understood among the patient group, as it is not among Anglo-American laymen. Modern medicines are sometimes thought to be merely refinements of traditional remedies and hence not much superior to the more familiar, less expensive **remedios**. For some people and some illnesses, conviction that scientific practitioners or medicines are clearly superior to traditional ones may be lacking. Professional medicine is one among several alternative resources that can be drawn upon to deal with illness. In some instances it may be the preferred alternative; in others, other alternatives may take precedence. Choice in a given case (within the limitations of availability and ability to pay) is likely to be based on factors of familiarity, convenience, and empirical evidence of what has been successful with similar ailments in the past.

PRACTITIONERS

Several kinds of practitioner are available in the traditional medicine of the patient group. None, with the exception of the midwife, receives formal training. Knowledge and skills are acquired as a part of the normal process of living or through a kind of informal apprentice type association with a practitioner who is, generally, also a relative. It is likely that the number of practitioners in any category is decreasing as old knowledge and old skills are supplanted by newer ways.

As noted above, some patients tend to equate professional practitioners. If an illness occurs, relief of symptoms will have a high priority; efforts to attain such relief may involve shifting from traditional to professional practitioner or the other way. As we all do, patients tend to lean heavily on their own past experience in approaching new problems, and it is not unusual for a person under professional treatment to seek supplementary aid from traditional practitioners or family members and to attribute subsequent recovery to the more familiar remedies and ministrations.

Relatively little distinction is made among the several types of professional practitioners. It is felt that a sick person must have faith in his doctor as he does in the treatment materials and procedures, and those whose behavior is such as to instill confidence and faith are likely to be preferred over those who do not, regardless of the type of professional training.

Traditional practitioners and their areas of competence and interests are:

Partera - (Midwife)

A **partera** is usually an older woman who has become expert at assisting in the delivery of babies. She will have an extensive

knowledge of herbs and remedies, and be experienced in the techniques of manipulation and the provision of emotional support. In addition, **parteras** are recognized by the health department, and may have received some formal training.

Medico(a) - Curandero(a) - (General Specialist in Folk Medicine)

This is a man or often a woman who has a greater knowledge of folk medicine than the ordinary layman. The medico(a) is able to treat a wide variety of diseases with remedies and/or therapeutic massage. This specialist is likely to be called for help when a sick person has not responded to home remedies and/or is dissatisfied with modern medical treatment.

Sobador(a) - (Specialist in Massage)

This is a man or woman who is recognized as an expert in the administration of therapeutic massage and in setting broken and dislocated bones.

Albolario(a) - (practitioner of Benevolent Magic)

This is a man (usually) or woman who specializes in the treatment of victims of witchcraft. There are very few of them.

Note: There are no precise boundaries separating the activities of the above specialists. For example, a man may be known both as a curandero and as an albolario. Since witchcraft is a very sensitive topic, it is best not to question patients about witchcraft, e.g., their knowledge of witches **(brujo(a)s)** or their possible contract with **albolario(a)s**.

FIRST VISIT

The first visit is especially important since relations established then may favorably or unfavorably influence what happens in all future contract.

1. **To help establish good rapport:**

   a. Use polite terms when addressing adults, e.g., Mr.–Mrs.–Senor–Senora–with your permission.

      In polite social intercourse first names are **not** used especially if patient is older than nurse. **Do not use** first names!

      In home visit accept the more **formal** atmosphere for professional conversation e.g., living room (a way of showing respect to patient.)

   b. Try not to given an impression of being in a hurry and do not expect patient to make an immediate decision (he or she may have to consult other family members before making a final decision.

   c. Use a few Spanish words if you know any.

   d. If the patient's behavior gives signs that lead you to think you are not being clearly understood:

      (1) As if the patient would like an interpreter.

         (Remember that the word "interpreter" may not be understood and you may have to say something like: "Would you like someone here who could tell you in Spanish what I am saying?")

         (a) If yes:
            1. Let the patient select the interpreter.

2. Explain only who you are and why you come.
3. Make your visit short and informal; do not attempt any formal health teaching.
4. Plan to return with a Health Department interpreter.

(b) If **no**:

1. Speak slowly; use only short sentences and simple words.
2. Make your visit short and informal. Concentrate on obtaining identifying information rather than on the transmission of health information.
3. Plan your next visit in terms of cues provided by identifying information.

2. In deciding whether it is best to use English or an interpreter consider the following cues:

a. English is more likely to be understood when:

(1) English is spoken in the home.
(2) The person to whom you are talking has a 6th grade education or more.
(3) The person to whom you are talking is under 30 years of age.
(4) The family contains no more than five children.
(5) The breadwinner holds a skilled labor position or a higher one.

b. An interpreter is more likely to be needed when:

(1) English is not spoken in the home.
(2) The person to whom you are talking has less than a 6th grade education.
(3) The person to whom you are talking is over 30 years of age.
(4) The family has six or more children.
(5) The breadwinner is unemployed or works as an unskilled laborer.

c. You will, of course, want to take account of any other factors you may notice that provide cues on which to base a decision about language. If you decide that English can be used, do not then use an interpreter. To do so may introduce misunderstandings or may offend the patient. (See Arguments and Explanations.)

3. After the interview note in the family folder:

   a. Whether an interpreter is needed for this person.
   b. Any folk beliefs or practices that come out during the interview. This will help you evaluate how to handle the next visit as well as help other nurses who may be working with the patient.

INTERPRETER

Before using an interpreter, the nurse should receive training in the use of an interpreter (she should know how to use an interpreter and feel competent using one).

When using an interpreter the risks of misunderstanding are generally increased. Be very skeptical of information obtained by you and of the clarity with which information has been received by the patient. Double check to insure accuracy if the information is important.

(Do **not** ask: "Do you speak English?")

1. If you are in doubt about using an interpreter, ask the patient if he would **like** one. When no trained interpreter is available **allow the patient to choose** a local interpreter. He may not want the usual local interpreter to have access to his **private** information.

2. A **trained** health department interpreter should be used whenever possible, especially if health teaching is a purpose of the interview.
   a. Untrained, local persons serving as interpreters increase the possibility of misunderstanding.
   b. The patient may be reluctant to discuss personal or family affairs in the presence of a local person.

3. Whenever possible have a pre-interview discussion with the interpreter to explain the purpose of your visit and the kinds of understanding that you wish the patient to achieve. If you think it is going to be necessary to transmit technical information go over the concepts and explanations with the interpreter to be certain that he clearly understands them. Give him simple explanations of technical or difficult concepts that he may use in translation. (See **Explanations.**) Inform the interpretor **before** he

begins interpreting that his ideas are not to be expressed in either direction (this occurred often). Check with the interpreter when necessary to make sure he is understanding the message. The nurse should very carefully avoid conveying any sense of time urgency during the discourse. It is very important that nurse and interpreter have a good working relationship in order to obtain the very best from an interpreting session.

4. When using an interpreter:
   a. Speak directly **to the patient** in a natural voice. **Do not ignore patient.**
   b. Have the interpreter stand slightly behind you so that he is not between you and the patient.
   c. Present one idea at a time in one or two short sentences. Then wait for the translation. Do not expect the interpreter to hold in mind long, involved explanations or instructions.
   d. As the interpreter to translate as completely as possible **everything** you and the patient say. If necessary have him caution the patient to wait after every idea for the translation.
   e. **Look at** and **Listen to** the patient so that he addresses himself to you, not the interpreter.
   f. Avoid technical terms that you have not previously discussed with the interpreter. (If you must use technical terms try to anticipate them and to discuss with the interpreter before the interview how they are to be translated. **Remember**: a word that may not seem technical to you may be out of the experience of the patient.)
   g. Do not interrupt either the patient or the interpreter when they are speaking. To do so may impair rapport and may block communication of important messages.
   h. Observe the forms of address that the interpreter uses and follow his example.

5. **After** using an interpreter:
   If possible follow the interview with a discussion with the interpreter to get his views about what he thought the patient did or did not understand; what he thinks was the patient's general response to your explanations and requests; what concepts or

ideas he thinks may not have come through well in translation; and how he thinks the communication might have been improved.

6. Remember that the sole function of an interpreter is to put into the most comparable Spanish the things you say in English and to communicate to you in English the best approximation of what the patient said in Spanish. The interpreter must know that his ideas are not to be expressed in either direction.

ARGUMENTS

The nurse should acquaint herself thoroughly with the difference between "health" and "organizational" concepts in order to be able to use this section adequately.

Health arguments are requests that a patient do something relating to health (e.g., attend a clinic, have an X-ray, eat more vegetables, have a child vaccinated) together with one or more reasons explaining why that action should be done. When presenting health arguments it is advisable to:

1. Avoid technical terms and concepts. Insofar as possible use alternative words and explanations pitched to your estimate of the patient's ability to understand. In most cases it is probably better to err on the side of talking too simply than to run the risk of talking "over the head" of the patient.

2. If technical concepts are necessary, try to present them along with simple, clarifying definitions (See **Explanations.**) Learn to use words that have a similar sounding counterpart in Spanish (e.g., negative–negativo) and to avoid words that have similar sounds in English and Spanish, but different meanings (e.g., tease–tis).

3. Give simple, explicit directions together with an appropriate reason.

4. Use reasons that correspond with the type of request: appropriate health reasons for the health acts and organizational reasons for organizational acts. For example:
   a. "It would be best for you to come to the chest clinic in Santa Fe (organizational request) so that we can X-ray your chest." (organizational reason)

b. "You should get your chest X-rayed (health diagnostic action) to find out for sure if your lungs are all right." (health diagnostic reason)

c. "Take one of these pills just before every meal (health treatment action) so they can help you get over this sickness." (health treatment reason)

d. "Your daughter should be vaccinated now (health preservation activity) so she will not get smallpox." (health preservation reason)

Note that organizational requests and reasons are generally not highly motivating for patients. It is necessary to give them, but they should be followed by appropriate health requests and reasons so that both the action and the result are meaningful to the patient. For instance, example "a." above does not **explicitly** state any benefit to the patient; but if it is followed by example "b." a complete chain of events and reasons with explicitly stated benefits to the patient will have been presented. (**You** come to the clinic so **your** chest can be X-rayed; **you** need a chest X-ray so you can find out if **your** lungs are all right.)

5. Use relatively "weak" language in the request, such as "ought" or "should" or "it might be best if you. . ." together with a "strong" reason, i.e., one that indicates the most appropriate, direct, and desirable benefit to the patient. Avoid "must" type directives.

6. Early in the health discussion part of an interview explicitly state the basic premise common to both village and public health belief systems—that one should do whatever is necessary to regain or protect his health. There are many ways of stating this idea. You should use the form you think best suited to the immediate situation. Examples of how the idea may be expressed are:

a. It is best for you to do things you know will protect your health.

b. I am sure you will want to do anything that will help you get well.
c. Of course you will want to do anything that will keep you healthy.
d. I know that you are willing to do everything possible to see that your baby grows up to be a healthy child.

7. Use health reasons to support health directives rather than reasons that call upon a sense of social obligation or religious beliefs (i.e., "Do this because it will help you get well or keep you well," rather than "Do this because "God wants you to"). Since frequently village people do not believe they are capable of transmitting infection to others, it is better to use the benefit to the patient rather than benefit to others as a health reason. If a health argument, in your opinion, needs to be reinforced by some other kind of reason, it is probably best to use an authoritarian reason. For example:
   a. "You need to get this sputum test done (health diagnostic request) to find out if you have tuberculosis." (health diagnostic reason). This would be first choice as a form of argument.
   b. "The doctor knows what is best for you (authoritarian reason), and he thinks you ought to have this sputum test done right away." (health diagnostic request). This form of argument is advised as a supplement to the health request-health reason pattern when reinforcement is thought necessary.

8. Keep organization arguments, like "You should come to the clinic to get an X-ray," clearly separated from health arguments, like "You need an X-ray to see if your lungs are all right." If the health prescription is not clearly stated with a **health** reason, the desired health act–getting the X-ray–is left implicit as the validation in the organizational argument. The result is confused understanding of the reason for coming to the clinic as compared with the reason for getting the X-ray.

9. Keep discussion of one problem clearly separated from discussions of other problems. Ideally, each interview should deal with a single problem.

10. Try to involve the person with whom you are speaking in the action you are suggesting (whether or not he is the patient). The person then actively participates in what is to be done and is more likely to see that it gets done.

11. Whenever possible try to include the husband in the discussion of what should be done and why. Most decisions that involve going to the doctor, taking X-rays, etc. are made by the husband and wife together, so it is important to try to explain things to the husband as well as the wife.

12. Give the patient an appointment card or other written material to help him recall what he is supposed to do, when, and where. Further written explanatory materials may be useful to remind the patient of the interview and help him better understand and retain what you wanted to transmit to him.

EXPLANATIONS

You will be using explanations to make something known or clear to patients that was not known or clear before. A good general procedure is to try to start with what you think the patient knows or understands and proceed from that into the less well known or understood areas. Specifically, it may be well to;

1. Whenever possible, use a linkage concept or idea as the basis for common understanding when trying to communicate a new idea. Examples of possible linkage areas:
   a. Resistance: a person is more open to sickness when he is weak, as he may be when he doesn't take care of a minor illness.
   b. Doctors and modern medicine are generally effective in dealing with disease.
   c. Sickness can spread from one person to another—tis prendido and measles, for example. How it spreads may not be well understood.
   d. The X-ray is a useful diagnostic procedure.
   e. Health experts (including doctors and nurses) know more about health and disease than the average person.

2. Avoid technical concepts if at all possible.
   Example: "The Heaf test tells us whether you have been exposed to tuberculosis at any time."
   Instead, say: "This skin test will tell us whether or not some of the little bugs that cause TB ever got into your body."

3. The first time a technical concept is introduced, explain it in simple language. Be sure your explanation is complete enough for clear understanding. It may be well to use simple illustrations out of the patient's experience.

4. Develop a vocabulary of simple definitions of commonly used technical concepts. For example:
   a. **Germs** - (Germenes que son animalitos - que causan enfermedad) Germs are tiny bugs that can get inside you and cause you to get sick. The germs are so little they can be seen only with a special instrument, which is like a powerful magnifying glass, but there are different kinds, and each kind causes a different disease.

(NOTE: MANY DEFINITIONS THAT FOLLOW PRESUPPOSE AN UNDERSTANDING OF THE GERM CONCEPT.)

   b. **Exposed** - (Expuesto - Contacto con) To be exposed to TB germs means that you have been someplace where the TB germs are, like near a person with TB who coughs and spreads the germs into the air where you can breathe them into your lungs.
   c. **Contaminated** - (contaminado - puerco) To be contaminated means that a thing is no longer pure–it has germs on it.
   d. **Transmitted** - (Transmitter - pasar) To be transmitted means that something gets from one place to another. For example, TB germs go from a person who has TB through the air to other people.
   e. **Resistance** - (Resistencia) Resistance means that your body is healthy and strong enough to fight off disease.
   f. **Infected** - (Infectado) To be infected means that germs have started growing and spreading and are damaging some part of the body.
   g. **Symptoms** - (Senas) Symptoms are those signs, such as fever, vomiting, etc., that show the beginning or presence of a disease.
   h. **Tuberculin Skin Test** - (Prueba - teste en la piel para el tis) A special kind of skin test that tells whether or not a person has ever gotten some TB germs in his body.
   i. **A Positive TB Skin Test** - (Prueba - teste positiva) A positive skin test means that at some time the person has had TB germs in his body. It does not mean he has TB now, but he should have a chest X-ray to find our for sure.

j. **A Negative TB Skin Test** - (Prueba - teste negativo) A negative skin test **usually** means that the person has never had enough TB germs in his body to do any harm.

k. **Sputum Test** - (Examinacion - prueba - teste de flema) A sputum test is an examination of phlegm which is coughed up from deep inside the lungs, and this test tells whether or not the TB germs are now growing in the lungs of that person.

l. **Isolate** - (Apartar - separar) To isolate a person is to keep him in a separate place away from other persons. This is sometimes done when a person has a disease that can spread to others.

m. **Relapse** - (Recaida) A relapse means that a person gets sick again after having started to get well.

n. **Respiratory Illness** - (Enfermedad de respiracion) A respiratory illness is one which affects breathing, such as an illness in the lungs, like colds, pneumonia, and TB.

o. **Primary TB** - (Comienzo del tis) A person has primary TB when the TB germs start harming the lungs for the first time, and the lungs often get healed by the body itself if the body has good resistance.

p. **Advanced TB** - (Tis avanzado) A person has advanced TB when the TB germs have eaten into the lungs and already made sores and holes there. This person is spreading TB germs to others.

5. For particularly important and difficult concepts, like "germs" and "infection," show pictures which will help the patient see the idea.

6. Start a discussion of germ theory with the facts about the spread of the disease before introducing the germ concept.

7. Be especially careful to avoid unnecessary technical concepts when explaining diagnostic or other procedures doctors use to determine a basis for health action. The general idea of "finding out" is more important than the particular way something is found out.

   Example: "The sputum is sent to a laboratory where they do a culture on it. And if the TB germs start growing there they know that the germs are in your lungs."

Instead, say: "With a sputum test the doctor can find out if there are TB germs now growing in your lungs."

8. In difficult communication situations, appeal to the authority of the doctor. The result may be more communication and a stronger argument then the use of an argument depending on knowledge of difficult technical concepts.
   Example:
   Nurse: "You need to have the sputum test to find out if you really have TB in your lungs."
   Patient: "But I am not sick—I am strong. I work and feel well."
   When the patient resists like this, you may do well to use an authoritarian argument.
   Nurse: "The doctor is trying to help you protect your health, and he knows what is best for you to do. The doctor has examined your chest X-ray, and now he thinks there may be something wrong, and that you should have a sputum test."

9. Do not belittle a patient's beliefs or try to argue him out of his folk belief. If no other alternative is available, show respect for the patient's belief and simply "add on" the new idea, possibly with an appeal to the doctor as a health authority.

10. Adjust your use of language and technical concept explanations to a level appropriate for the particular patient. An adequate explanation for a well-educated, bi-lingual person may be inadequate for a poorly educated one.

11. Remember that your patients, like all of the rest of us, get most of their knowledge from other people. People who are defined as "authorities" or "people who know" are more likely to be listened to and believed than other people. You are such an "authority" for most villagers because of your position. But in the area of health there are other "authorities," some of whom are closer to patients, better known by them, more like them than you are. If your explanation does not agree with what the patient already knows or with that of these other authorities, and there is no clear (to the patient) evidence to show yours to be a better explanation, the others' explanations

may be accepted in preference to yours. You, therefore, need to be careful to start with something the patient already knows and to make your explanations as clear, convincing, and complete as your technical knowledge and verbal skills permit. When you can honestly do it, cite local evidence to support your arguments and explanations.

For example: "Your neighbor, Pedro Escalante, you will remember, thought he wasn't sick. But he went for an X-ray and was found to have tuberculosis. Because he found out about it and got it treated early, he is now well." Or, "You may have noticed that since we started giving shots to babies, there is not much diphtheria around here any more."

FOLK ATTITUDES RELEVANT TO PUBLIC HEALTH

1. Villagers generally have a sincere appreciation for the services that the public health nurse renders.

2. Home remedies and folk practitioners are likely to be used before nurses and doctors.

3. Prolonged family consultation usually precedes the decision to use a doctor.

4. For many ailments, several kinds of health authorities–nurses, chiropractors, osteopaths, and various types of M.D.'s, as well as folk practitioners–may be considered equally competent.

5. Public health services are accepted most readily in areas where success has been demonstrated (e.g., immunizations, prenatal and well child conferences) and where immediate results can be shown (e.g., treatment for dental problems, V.D., cardiac defects, visual handicaps).

6. Resistance to public health teaching and practice is most likely to occur in the attempt to educate villagers about germ theory and the oral transmission of disease, and in the attempt to introduce new practices in the areas of personal and environmental sanitation.

7. Both supernatural and natural concepts are used to account for the cause and cure of illness. There are varying degrees of adherences to Spanish-American health beliefs. Nurses should not reject or belittle medical folk beliefs or practices of their patients but, whenever possible, in stating scientific beliefs and practices relate them to beliefs held.

8. The folk medical specialists are highly respected.

9. Religion plays an important role in Spanish-American life, so religious obligations may override conflicting health considerations.

10. Attitudes towards diseases, disability, and death may be somewhat more "fatalistic" or accepting than those held by public health practitioners.

11. Family and community obligations with respect to health may sometimes be interpreted in terms of traditional values rather than public health values; e.g., it may be thought preferable to keep an ill member in the home and community, even at the risk of spreading infection to others, than to "abandon" him to the care of strangers.

12. There are no definable group resistances to public health programs or practitioners.

13. Folk medical beliefs are not generally antithetical to public health beliefs.

14. Although the patient may be able to repeat verbatim what the nurse says this does not mean this is what he really believes.

GENERAL RULES

Remember:

1. The ability to understand and speak English, the adherence to folk medical beliefs, the level of understanding of Anglo medical theories, the cooperation of a patient with the health department–vary a great deal in the Spanish-American population, due to differences in languages used in the home, amount of education, age, occupation, amount of contact and type of previous experience with the Health Department. Use such cues in deciding how to approach and talk with a patient.

2. Superficially, an individual may appear very acculturated, yet he may not really accept Anglo values and beliefs, but may retain those of his own ethnic group. On the other hand, an individual who seems to have hardly accepted Anglo ways at all may know about and be at ease with highly sophisticated medical ideas and practices.

3. Observe the patient's reactions. Signs such as short, jerky answers or general uneasiness may be an indication that you are not getting across, or that an interpreter is needed, or that rapport is on the verge of breaking down.

4. Make frequent, more intensive home visits (at least every three weeks) in those cases where it is important that a concept be understood clearly.

5. Provide a setting in nursing conferences which allows privacy, so that the patient can talk and listen without embarrassment or frequent interruption. Examine the present situation in the nursing conferences and see what you can do to improve it.

6. Try to develop a knowledge of who is related to whom in a group of villages so as to make the best possible use of already established relationships.

7. Use forms of address that will indicate to the patient that you respect him.

8. Try to avoid giving the appearance of being in a hurry.

9. Patients are more likely to cooperate if they perceive the interaction as being meaningful and beneficial to them or their interests.

GPO 886-491